GENERAL INSTRUCTIONS

Attached is a copy of the new application for use by out-of-hospital ground emergency medical services. This application can be used for either initial certification or recertification.

The application must be used by the following ground EMS agencies seeking initial certification or recertification under 7 AAC 26.210 – 7 AAC 26.999:[1]

- Basic Life Support (BLS) Services;
- Advanced Life Support (ALS) Services; and
- BLS services that sometimes provide ALS.

This application is not to be used for the certification of air medical services under 7 AAC 26.310 – 7 AAC 26.999.

Returning the application:

The completed application should be returned to:

EMS Ground Ambulance Certification
Section of Community Health and EMS
Division of Public Health
Department of Health and Social Services
P.O. Box 110616
Juneau, AK 99811-0616

If necessary, the application can be faxed to (907) 465-4101 prior to mailing the original.

Deadlines

By statute, a "person, organization, or government agency that provides, offers, or advertises to provide an emergency medical service may not provide advanced life support services unless authorized under AS 18.08.082." [2] Consequently, an applicant for initial certification as an out of hospital emergency medical service which intends to perform advanced life support must become certified before doing so.

An applicant for recertification must ensure that the completed application is received by the Section of Community Health and EMS prior to the expiration date listed on the service's current certificate.

Questions

For answers to questions regarding the application or the application process, contact the Section of Community Health and EMS.

Telephone: (907) 465-3028
FAX: (907) 465-4101
e-mail: shelley_owens@health.state.ak.us

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1 A copy of these regulations are available for downloading from the section's web site at: http://www.chems.alaska.gov

2 AS 18.08.084

APPLICATION FOR CERTIFICATION AS AN "OUTSIDE HOSPITAL" EMERGENCY MEDICAL SERVICE

Our organization is applying for:

☐ Initial Certification
☐ Recertification

as a/an:

☐ Basic Life Support (BLS) Service
☐ BLS Service with Advanced Life Support Available Some of the Time
☐ Advanced Life Support Service (ALS)

EMS OFFICE USE ONLY
Received:

Issued:

Expires:

Cert. #:

☐

1. Legal Name of Organization/Agency: _____

2. Medicare Number: (Optional): _____

3.

Address	
Mailing	Geographic/Physical

4. Head of Organization/Agency: _____ JobTitle: _____

5. Telephone of Head of Organization/Agency: Business:_____ Home:_____
Fax (Business): _____
e-mail contact: _____
Web site: _____
24-hour Dispatch number: _____

6. Type of 'outside hospitals' emergency medical service (check one):

☐ Independent Vol. Service
☐ Hospital Based
☐ Fire Dept. Service
☐ Volunteer Fire Dept. Service
☐ Police Dept. Service
☐ Commercial
☐ Military
☐ Other (please specify):
_____
_____

7. Name of Designated Officer for purposes of Ryan White activities (in the absence of service personnel trained in infectious disease issues and reporting, we recommend that the service's physician medical director serve as the Designated Officer):

_____
(Name) (Phone #)

8. Date physician-signed standing orders were last: _____ _____ by physician.

Reviewed Revised

9. List all physician medical directors:

I verify that I will fulfill the requirements in state regulations 7 AAC 26.610-7 AAC 26.690, including annual review of treatment protocols (standing orders):

#	Name	License #	Signature
1.			
2.			
3.			

Note: The physician medical director must sign before submitting application. (If the physician medical director is affiliated with the Indian Health Service or the military, please indicate state(s) of license and license number(s).

10. Name of person(s) responsible for continuing medical education program:

#	Name	Contact Telephone
1.		
2.		
3.		
4.		

11. Verify that you have all of the necessary equipment to perform medical procedures (basic and advanced) within the skill levels of available certified personnel. Use Appendix I "Inventory of Ambulance Supplies and Equipment," pages 5-9.

12. Check the appropriate box about enclosure of your EMS report form:

☐ Enclosed Own Report Form ☐ Enclosed Alaska Pre-Hospital Report Form

Enclosure of a copy of your EMS report form is required in regulations 7 AAC 26.245. If you do not have an EMS report form which meets state requirements, the Alaska Pre-Hospital Report Form (#06-1368) may be obtained from Community Health and Emergency Medical Services Section, Division of Public Health. Department of Health & Social Services, P.O. Box 110616, Juneau, Alaska, 99811-0616. (When requesting Alaska Pre-Hospital Patient Report Forms, please indicate the number of forms needed).

Send me _____ Alaska Pre-Hospital Patient Report forms.

13. List all certified personnel, such as emergency medical technicians (EMTs) I, II, or III, mobile intensive care paramedics (MICPs), or other certified or licensed medical personnel, involved in the transportation and care of patients. (Indicate name, level of certification, certification/license number, and expiration date.)

#	NAME	LEVEL OF CERTIFICATE	STATE CERTIFICATE/ LICENSE NUMBER	EXPIRATION DATE
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				
17.				
18.				
19.				
20.				
21.				
22.				
23.				
24.				
25.				
26.				

AFFIRMATION:

I hereby affirm that _____(Name of Service) will comply with all rules and regulations of the Department of Health & Social Services 7 AAC 26.210 – 7 AAC 26.290, to include:

1a) **(For BLS services)** Having an emergency medical technician I, and one other person to act as driver when using a surface transportation vehicle, available to respond to emergencies 24 hours a day.

1b) **(For ALS services)** Having an emergency medical technician II or III, mobile intensive care paramedic, or other medical personnel certified or licensed to provide advanced life support (e.g., registered nurse, physician's assistant, or physician), and at least one other person trained to at least the basic emergency medical technician I level when using a surface transportation vehicle, available to respond to emergency calls 24 hours a day.

2) Providing a continuing medical education program that will enable certified emergency medical personnel to meet state recertification requirements;

3) Maintaining a direct communications capability with a physician, hospital, or mid-level practitioner, unless the department grants a waiver due to technical communications problems. (If a waiver is requested, please submit and explain on a signed affidavit.)

4) Completing an approved EMS report form for each patient treated. The report form must document vital signs and medical treatment given the patient. A copy of the completed EMS form must:

a) accompany the patient to the treatment facility;

b) be sent to the physician medical director; and

c) be kept by the EMS service as a permanent record.

_____
(Name of Head of Agency/Organization)

(Title)

(Signature)

(Date)

VERIFYING STATEMENT:

In the presence of a notary public, postmaster, clerk of court, judge, magistrate, state trooper, or authorized state employee, if such official is available, applicant must sign here. **I certify under penalty of perjury that the foregoing is true and accurate.**

_____ _____
(Signature of Applicant) (Date)

THIS IS TO CERTIFY that on this ____ day of _____, 200____, before me appeared _____, to me known and known to me to be the person named in and who executed the foregoing instrument and acknowledged voluntarily signing and sealing the same.

_____
(Notary Public, Postmaster, Clerk of Court, or Judge, Magistrate, State Trooper, or authorized State employee)

My Commission Expires
or
My Badge Number is _____

APPENDIX I

INVENTORY OF AMBULANCE SUPPLIES & EQUIPMENT

1. Please verify with a **check mark** that the following minimum BLS equipment will be carried on board all ambulances at all times. An agency applying for certification or recertification as a basic life support service needs only to complete the BLS Equipment section of Appendix I. Agencies applying for certification as a BLS service providing Advanced Life Support some of the time or as an Advanced Life Support service must complete the sections of this appendix which relate to the skills used by the EMS agency's providers listed on page 3 of this application.

Basic Life Support (BLS) EQUIPMENT/SUPPLIES

VENTILATION AND AIRWAY EQUIPMENT:

- ☐ Oxygen, permanent - tank shall have a minimum capacity of 3,000 liters with reduction gauge & flowmeter
- ☐ Portable oxygen tank with regulator
- ☐ Adult bag-valve-mask with reservoir and mask
- ☐ Pediatric bag-valve-mask with reservoir and pediatric mask
- ☐ Infant bag-valve-mask with reservoir and infant mask
- ☐ Oxygen connection tubing
- ☐ Non-rebreathing masks, adult and pediatric sizes
- ☐ Oxygen masks, infant
- ☐ Oxygen cannulas, adult and pediatric
- ☐ Portable suction unit
- ☐ Suction catheters (6F-14F)
- ☐ Rigid suction tip (e.g., Yankaur)
- ☐ Pediatric bulb syringe
- ☐ Suction rinsing water bottle
- ☐ Oropharyngeal airways (00-5), adult, pediatric, and infant
- ☐ Nasopharyngeal airways, sizes 18F-34F or 4.5 - 8.5 mm
- ☐ Water-soluable lubricant

IMMOBILIZATION EQUIPMENT:

- ☐ Stretcher, main - shall be four-wheeled elevating cot for primary patient with appropriate patient restraining device
- ☐ Stretcher, portable - with appropriate patient restraining device
- ☐ Cervical collars, adult and pediatric
- ☐ Cervical immobilization device, adult and pediatric (sandbags may not be used)
- ☐ Long spine board
- ☐ Short backboard, KED, or equivalent
- ☐ Pediatric backboard, or equivalent
- ☐ Traction splint, adult and pediatric
- ☐ Extremity splints, adult and pediatric (e.g. vacuum, air, padded board, etc.)
- ☐ Infant car seat (desirable but not required)
- ☐ Restraints, patient

INVENTORY OF AMBULANCE SUPPLIES & EQUIPMENT – continued

BANDAGING EQUIPMENT:

- ☐ Universal dressings or trauma dressings
- ☐ 4 x 4 gauze pad packs
- ☐ Roller bandages (eg., Kerlex or Kling type)
- ☐ Adhesive tape, various sizes
- ☐ Burn sheets, sterile
- ☐ Triangular bandages with safety pins
- ☐ Trauma shears
- ☐ Occlusive dressings

OBSTETRICAL:

- ☐ Obstetrical kit, sterile
- ☐ Thermal blanket (to help newborn maintain body heat)

MISCELLANEOUS:

- ☐ Blood pressure cuff, adult, pediatric and infant; in addition, large adult size recommended
- ☐ Stethoscope
- ☐ Activated charcoal, 25-50 grams
- ☐ Substance high in sugar for treatment of diabetic patients
- ☐ Glasgow Coma Scale reference
- ☐ Pediatric Trauma Score reference
- ☐ Emesis basin, urinal, bed pan
- ☐ Blankets
- ☐ Sheets
- ☐ Pillows
- ☐ Sterile saline for irrigation

SAFETY:

- ☐ Safety flares
- ☐ 5 lb. fire extinguisher, dry chemical
- ☐ Flashlight
- ☐ Safety goggles
- ☐ Protective gloves, leather (one pair)
- ☐ Hammer, Phillips screwdriver, regular screwdriver, adjustable wrench, and pliers
- ☐ Body fluid isolation devices and supplies (gloves, masks, gowns, eye protectors)

Other EMT-I medications/equipment carried:

- ☐ _____
- ☐ _____
- ☐ _____

COMMUNICATIONS:

- ☐ Two-way communications radio _____ _____
  (Make) (Frequencies)

2. Please check equipment or medications available on each ambulance used to perform those procedures delineated in your standing orders. If you are an EMT-III service, fill out the EMT-II section, also. If you are a mobile intensive care paramedic service, complete the EMT-I, EMT II, EMT-III and MICP sections.

INVENTORY OF AMBULANCE SUPPLIES & EQUIPMENT – continued

MANUAL DEFIBRILLATOR TECHNICIAN

☐ Monitor/Defibrillator (Manual)

Advanced Life Support (ALS) EQUIPMENT/SUPPLIES

EMT-II EQUIPMENT/SUPPLIES:

☐ Advanced Airway Device (Type: _____) and associated administration equipment
☐ Naloxone HCI
☐ 50% Dextrose in Water
☐ Balanced Salt Solution (e.g., normal saline)
☐ Syringes of various sizes
☐ Needles of various sizes
☐ Three-way Stopcocks (desirable but not required)
☐ Tubes for Blood Samples
☐ Pediatric Medication Dosage Chart
☐ IV Catheters (14-24 Gauge)
☐ Intraosseous Needles
☐ Mini (60 gtts/cc) and Maxi (10, 12, or 15 gtts/cc) IV Sets

Other EMT-II medications carried:
☐ _____
☐ _____
☐ _____
☐ _____

EMT-III EQUIPMENT/SUPPLIES:

☐ Monitor/Defibrillator
☐ Pediatric paddles/patches for defibrillator
☐ Monitoring electrodes - adult and pediatric sizes
☐ Defibrillator Gel/Pads
☐ Lidocaine 1% or 2%
☐ Lidocaine 20% or pre-mixed bag for drip
☐ Morphine Sulphate
☐ Epinephrine 1:1,000
☐ Epinephrine 1:10,000
☐ Atropine

Other EMT-III medications carried:
☐ _____
☐ _____
☐ _____
☐ _____

INVENTORY OF AMBULANCE SUPPLIES & EQUIPMENT - continued

PARAMEDIC EQUIPMENT/SUPPLIES: (Please indicate which paramedic medications you carry)

- ☐ Isuproterenol
- ☐ Diphenhydramine
- ☐ Bretylium
- ☐ Propranolol
- ☐ Furosemide
- ☐ Intropin
- ☐ Aminophylline
- ☐ Diazepam
- ☐ Corticosteroids
- ☐ Varapamil
- ☐ Procanamide
- ☐ Quinidine
- ☐ Nitroglycerin
- ☐ Phentoin Sodium
- ☐ Albuterol
- ☐ Nitrous Oxide
- ☐ Pitocin
- ☐ Paralytics
- ☐ Laryngoscope with blades, adult and pediatric sizes
- ☐ ET Tubes (uncuffed sizes 2.5 - 6.0; cuffed sizes 6.0 - 8.0)
- ☐ End tidal CO_2 detection device
- ☐ Magill Forceps – adult and pediatric sizes
- ☐ ET tube stylet - adult and pediatric sizes

Other MICP medications carried:

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

3. Equipment/supplies needed or missing (specify):

4. Please place a check mark next to the following optional equipment used by your service:

- ☐ Blood glucose monitoring system
- ☐ Automated external defibrillator
- ☐ Nebulizer system
- ☐ Nasogastric tubes

5. Please list other optional equipment or supplies you carry which you wish to have listed in your records (on attached sheet):

INVENTORY OF AMBULANCE SUPPLIES & EQUIPMENT - continued

6. Do you have sufficient equipment, supplies and medications to provide advanced life support procedures that are outlined in the standing orders signed by your physician medical director?

☐ Yes ☐ No

7. Do you have equipment and supplies which enable you to comply with the OSHA/State bloodborne pathogen requirements (18 AAC 61.17)? ☐Yes ☐ No If "No," please explain:

_____
_____
_____
_____

8. List vehicles operated by the organization/agency requiring licenses:

#	MAKE (Chevy, Ford, etc.)	MODEL & YEAR	VEHICLE SERIAL NUMBER	VEHICLE LICENSE NUMBER
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				

For agencies having more than 12 vehicles, submit this information for each vehicle.